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Michigan Long-Term Care Supports and Services Advisory Commission
Meeting of May 24, 2010
Capitol View Building, Lansing, MI

- Agenda – Monday, May 24, 2010
- MDS 3.0 Version –*Power Point*
- MI Choice Update –*Power Point*
- Letter to DCH Director RE: Health Insurance Reform Coordinating Council
- Press Release March 31, 2010 – Governor established a Health Insurance Reform Coordinating Council
- E.O. No. 2010-4 Implementation of the Patient Protection and Affordable Care Act
- State Profile Tool Grant Update
- Commission Workgroups:

  Updated – Finance Reform Workgroup TF Recommendation #9 – Responsible/Status

  Consumer Participation & Education Workgroup TF Recommendation #6 – Consumer Inclusion/Value of Consumers

AGENDA

MICHIGAN LONG-TERM CARE SUPPORTS AND SERVICES ADVISORY COMMISSION
Monday, May 24, 2010
10:00 a.m. – 3:30 p.m.
Capitol View Building, Lansing
1st Floor Conference Center

10:00	I.	Call to Order/Roll Call	RoAnne Chaney, Chair
	II.	Review & Approval of March 22, 2010 Minutes	
	III.	Review & Approval of Today's Agenda	
10:15	IV.	Implementation of MDS 3.0	Melanie Nabozny, Plante & Moran Roxanne Perry, MDCH
11:15	V.	Medicaid LTC Policy Update	Susan Yontz, MDCH
	VI.	Home & Community-Based Services Update	Michael Daeschlein, MDCH
12:00		Lunch	
1:00	VII.	Public Comment	RoAnne Chaney
	VIII.	LTCSS Provisions of Health Care Reform	Pam McNab, OSA
		A) Action Item: Letter to DCH Director regarding the Governor's new Health Insurance Reform Coordinating Council	RoAnne Chaney
1:45	IX.	OSA – Grants Update	
		A) System Transformation Grant	Pam McNab, OSA
		B) State Profile Tool	Jane Church, OSA
2:15	X.	Commission Workgroups	RoAnne Chaney
		A) Updates from Finance and Consumer Involvement (Quality to be deferred)	
		B) Executive Committee Recommendation on Restructuring the Workgroups – Discussion	
3:00	XI.	Commission Discussion	
		A) Action Items	
		B) July Agenda Items	
		C) Commission Announcements	
3:30	XII.	Adjournment	

The next meeting is July 26, 2010 at 10:00 a.m. at the Capitol View Building, 201 Townsend Street, Lansing, 1st Floor Conference Center.

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MDS 3.0 Implementation

Melanie Nabozny, RN
Plante & Moran, PLLC
May 24, 2010

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Today's Topics

- Examine the major changes to MDS 3.0
- Discharge Planning
- Identify the impact that MDS 3.0 and RUGs IV will have for the facility come Oct. 1, 2010

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MDS 3.0

- **MDS 3.0 set for implementation October 1, 2010**
- MDS 3.0 is not a revision of the MDS 2.0 but a whole new document. **Impacts the entire interdisciplinary team**
- **Training will be vital – facilities must budget**
- Will have to manage 2 systems – learn MDS 3.0, but remain masterful with MDS 2.0 and RUGs III
- **Strategies will be very different**

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The 10,000 Foot View of the MDS 3.0

- Resident Centered Assessment – improved resident input
- Greater Accuracy and Reliability
- Improved Validity – removed less valid items

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Remains Microscope of Operations

Data accuracy for survey process

Accurate representation of quality of care provided (QIs and QMs)

Reimbursement consistent with the care delivered

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Changes on the MDS 3.0

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Comprehensive (NC) Item Set

Section A	Identification Information
A0100.	Facility Provider Numbers
	A. National Provider Identifier (NPI):
	B. CMS Certification Number (CCN):
	C. State Provider Number:
A0200.	Type of Provider
Enter Code	Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed

MDS 3.0 Item Listing-Version 1.00.2 10/01/2010

MDS 3.0 Most Significant Changes

- Assessment types and when to use
- Multiple interviews with the resident
- Facility staff must be equipped to conduct effective interviews
- Look-back periods (when and where)
- Coding in Behavior, Skin, Bladder and Bowel, Balance and Fall History
- Expanded identification information and active diagnosis section
- Coding of therapy minutes
- Use of the Care Area Assessments
- Return to community

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MDS 3.0

- Resident Centered Assessment
  - Resident interviews (if resident unable to be interviewed then staff interviews)
    - C Cognitive Patterns
    - D Mood (result will impact 26 RUG groups)
    - F Preferences for Customary Routine Activities
    - J Health Conditions (Pain)
    - Q Participation in Assessment and Goal Setting
  - Staff interviews

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MDS 3.0

- The staff the resident is most comfortable with should be doing the interviews.
  - Who is that in your facility?
  - It may not be the same staff person for every resident
- Interviews are limited to the day before and day of the ARD (Assessment Reference Date)

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Process Changes on the MDS 3.0

- Adds self-reported (resident) interview items – more resident/person focused – hearing the resident's voice
- Scripted interviews  - detailed instructions
- Huge quality of care and quality of life implications based on resident's values, needs and priorities – promotes culture change now

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MDS 3.0

- Look-back is 7-days unless otherwise noted
- Mood is 14 days
  - Resident interview 9 items
  - Staff interview 10 items (+ short-tempered)
- Special treatments
  - "While a resident" (for RUG-IV grouping)
  - "While NOT a resident" (for care planning)
- Parental/IV feedings will include look-back into the hospital

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MDS 3.0

- The CATs ate the RAPs
  - Removing the phrase "The resident assessment protocols (RAPs) and triggers and replace it with Care Area Triggers (CATs)
  - The 18 domains for the RAPs would remain plus 2 new for the CATs
    - Pain
    - Discharge Planning

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MDS 3.0

- Discharge Planning – There is an entire section devoted to it and a CAT dedicated to it. "The Money Follows the Person". What will all this mean for facilities?
- CMS devoted a whole day during April's Train the Trainer sessions in Baltimore just to this very topic.
- Discharge Planning will take on a new meaning for facility personnel.

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The Interviews

- **Discharge Planning (Section Q)**
  - Focuses on resident's expectations for discharge
  - Supports their right to choice
  - Ability to obtain information about receiving services and support in the community
  - Reinforces states' efforts to comply with American with Disabilities Act (ADA)

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The Interviews

- **Discharge Planning (Section Q)**
  - A "yes" response to the return-to-community item requires the facility to initiate care planning and potentially refer the individual to a state-designated local contact agency (LCA)
  - Goes beyond whether a support person is positive toward discharge
  - Asked on admission, annually, quarterly and significant change in status

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Local Contact Agencies

- **Discharge Planning (Section Q)**
  - When an individual responds "yes" to wanting to speak to someone about returning to the community, the facility is required to make a referral to a LCA
  - State Medicaid Agencies will have to amend their Data Use Agreement (DUA) with CMS to share MDS data with the organization(s) that they create agreements with and designate to provide information to individuals about community and HCBC options

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Local Contact Agencies

- **LCAs can be:**
  - Center for Independent Living (CIL)
  - Area Agency on Aging (AAA)
  - Aging & Disability Resource Center (ADRC)
  - Money Follows the Person program (MFP)
  - Developmental Disabilities Administration
  - Mental Health Administration
  - Mix of these
  - Other

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Part A SNF PPS RUG Refinements for FY 2011

- Revise case-mix classification (RUG-IV) and implement in conjunction with MDS 3.0 (10/1/10)
- Increase RUG categories from **53 to 66** – based on changes found during the Staff Time and Resource Intensity Verification (STRIVE) project **(chart)**
- Accurate MDS more critical with increased dollars that focus on nursing services. Recalibration changes (we know case mix indices, but not rates):
  - Nursing CMIs = +18.2%
  - Therapy CMIs = -38.4%

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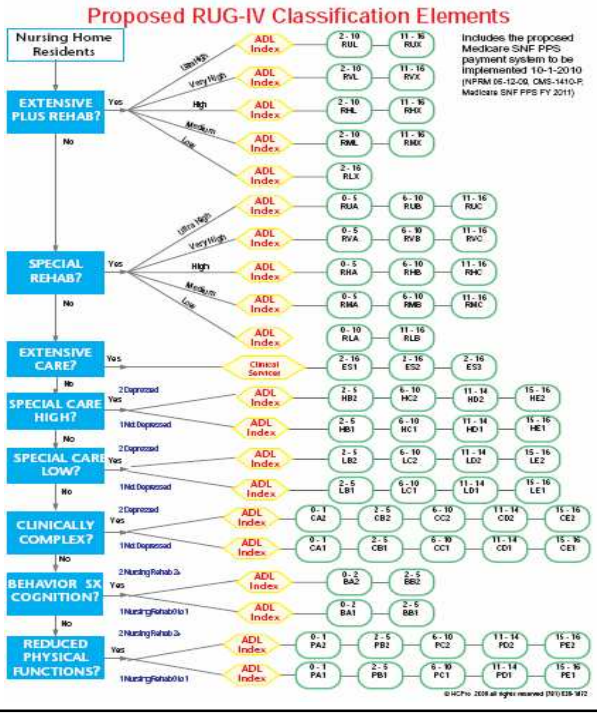
Impact on Reimbursement

- Shortened look-back periods = less time to identify indicators and capture services
- Look-back into hospital for care planning **NOT** for RUGs = much less chance to attain combined Rehab + Extensive (X/L groups)
- Items to capture Extensive Services changed = much less chance for attaining combined Rehab + Extensive Services
- Report therapy start and end dates = less Rehab RUG skilled days paid
- Isolation for <u>active</u> infections = new Extensive Services criteria
- Therapy more expensive with concurrent therapy limits



RUGs IV

- CMS indicates transition will be "budget neutral"
- Combo-Categories
  - Under RUGs III **36.5%** of all Medicare Days
  - Under RUGs IV **3.8%** of all Medicare Days
- Examples of trending in FY11 rate projections

Current RUGs III	
RUX	$621.42
RUC	$532.32
RMB	$328.34

Proposed RUGs IV	
RUX	$854.94
RUC	$625.14
RMB	$397.78

FY08 Part A Days of Service: RUGs III vs. RUGs IV

RUGs III						RUGs IV					
RUG-III Group	Original FY2008 DOS	Distribution	RUG-III Group	Original FY2008 DOS	Distribution	RUG-IV Group	Final Estimated FY2008 DOS	Distribution	RUG-IV Group	Final Estimated FY2008 DOS	Distribution
RUX	2,926,392	4.3%	SSB	571,443	0.8%	RUX	119,169	0.2%	HD1	950,125	1.4%
RUL	4,867,792	7.2%	SSA	893,467	1.3%	RUL	34,045	0.1%	HC2	214,419	0.3%
RVX	2,341,816	3.5%	CC2	113,659	0.2%	RVX	242,453	0.4%	HC1	877,895	1.3%
RVL	3,935,774	5.8%	CC1	319,328	0.5%	RVL	361,352	0.5%	HB2	529,288	0.8%
RHX	13,108	0.0%	CB2	241,193	0.4%	RHX	291,726	0.4%	HB1	900,447	1.3%
RHL	8,784	0.0%	CB1	703,444	1.0%	RHL	489,576	0.7%	HA2	530,506	0.8%
RMX	5,990,580	8.8%	CA2	207,507	0.3%	RMX	518,049	0.8%	HA1	413,736	0.6%
RML	4,631,760	6.8%	CA1	601,217	0.9%	RML	535,722	0.8%	LD2	36,827	0.1%
RLX	23,400	0.0%	IB2	10,598	0.0%	RLX	0	0.0%	LD1	470,734	0.7%
RUC	2,871,667	4.2%	IB1	90,793	0.1%	RUC	2,409,246	3.6%	LC2	192,709	0.3%
RUB	7,327,064	10.8%	IA2	3,644	0.0%	RUB	2,204,757	3.3%	LC1	884,520	1.3%
RUA	1,909,504	2.8%	IA1	68,394	0.1%	RUA	1,433,753	2.1%	LB2	176,879	0.3%
RVC	2,292,402	3.4%	BB2	400	0.0%	RVC	3,717,551	5.5%	LB1	403,636	0.6%
RVB	6,866,449	10.1%	BB1	6,012	0.0%	RVB	4,855,538	7.2%	LA2	13,287	0.0%
RVA	2,314,911	3.4%	BA2	698	0.0%	RVA	5,832,651	8.6%	LA1	232,348	0.3%
RHC	3,861,133	5.7%	BA1	13,172	0.0%	RHC	4,292,399	6.3%	CE2	101,146	0.1%
RHB	2,359,893	3.5%	PE2	21,426	0.0%	RHB	4,804,999	7.1%	CE1	144,124	0.2%
RHA	1,426,863	2.1%	PE1	142,978	0.2%	RHA	7,726,732	11.4%	CD2	394,377	0.6%
RMC	1,344,370	2.0%	PD2	36,647	0.1%	RMC	3,351,339	4.9%	CD1	477,406	0.7%
RMB	1,659,139	2.4%	PD1	224,126	0.3%	RMB	4,635,599	6.8%	CC2	243,494	0.4%
RMA	760,257	1.1%	PC2	3,513	0.0%	RMA	5,919,431	8.7%	CC1	455,042	0.7%
RLB	48,256	0.1%	PC1	29,903	0.0%	RLB	140,822	0.2%	CB2	436,939	0.6%
RLA	42,982	0.1%	PB2	2,861	0.0%	RLA	158,602	0.2%	CB1	361,746	0.5%
SE3	1,053,075	1.6%	PB1	32,827	0.0%	ES3	354,468	0.5%	CA2	215,403	0.3%
SE2	1,748,646	2.6%	PA2	4,006	0.0%	ES2	114,422	0.2%	CA1	953,346	1.4%
SE1	84,965	0.1%	PA1	158,025	0.2%	ES1	236,850	0.3%	BB2	45,144	0.1%
SSC	589,925	0.9%	Total	67,802,188	100.0%	HD2	25,107	0.0%	BB1	183,019	0.3%
									BA2	4,342	0.0%
									BA1	177,201	0.3%
									PE2	21,426	0.0%
									PE1	44,234	0.1%
									PD2	0	0.0%
									PD1	256,219	0.4%
									PC2	6,014	0.0%
									PC1	853,738	1.3%
									PB2	12,865	0.0%
									PB1	396,852	0.6%
									PA2	32,973	0.0%
									PA1	351,425	0.5%
									Total	67,802,188	100%

Consider from CMS data – assumptions made re: amount of concurrent therapy and hospital look-back periods:
FY10 RUX for 392 days times $621.42 = $243,601
FY11 RUX for 21 days times $854.94 = $17,954

Better for facility to figure own data based on RUGs IV

Part A SNF PPS RUG Refinements for FY 2011

- With calibrations facilities need to look at current admission process and contemplate how that might change with RUG-IV – will facility be able to manage care for more medically complex residents?
- ADL index compiled from the late-loss ADLs = bed mobility, transfer, toilet use and eating. Each ADL functional level given a score and summed up – changes made to improve scoring across all RUG categories so that residents with similar function scored similarly

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Part A SNF PPS RUG Refinements for FY 2011

- Adjustments to ADL index:
  - Scores from 0 to 16 (current 4-18)
  - "… ADL Index at 0 is intended to improve ease of use and interpretation..."
  - Range of scores for all 4 ADLs = 1 to 4
  - Parenteral/IV and feeding tube items not included in eating scoring
  - " …better categorize residents who receive feeding assistance"

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Part A SNF PPS RUG Refinements for FY 2011

- Concerns with Therapy
  - Revisions to calculation of therapy minutes
  - 90% of residents in Part A SNF stays receive therapy
  - Original intention was for 1- to -1 services
  - Growing trend to provide **concurrent therapy** (1 therapist treating multiple residents at same time while residents are doing different activities)

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Part A SNF PPS RUG Refinements for FY 2011

- **Group therapy** = 1 therapist provides same services to everyone in the group – coding restrictions for this type of delivery exist (no more than 25% of total weekly service per discipline can be in groups; ratio of 1:4)
- Currently no coding restrictions for concurrent therapy, but CMS acknowledges may be appropriate under certain circumstances (each gets total minutes)

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Impact on Current Practice for FY 2011

- CMS -- Concurrent therapy should never be the sole mode of delivering therapy
- CMS proposes to allow concurrent therapy if allocated to determine RUG-IV group
  - Therapist would allocate and track the total minutes of how much time was actually provided to each resident and how (individual, concurrent, or group)

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Therapy Calculation Changes FY 2011

- To code minutes on MDS these criteria required:
  1. Individual; or
  2. Concurrent – no more than 2 residents (regardless of payor source) both…in line-of-sight of therapist or assistant; or
  3. Group – no more than 2-4 (regardless of payor source); performing similar activities and supervised by therapist (or assistant) and not supervising any others

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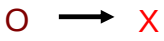
Therapy Treatment Models

Individual

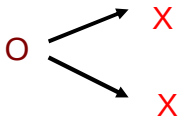
Therapist works with only 1 resident



Unallocated = 30 minutes

Concurrent

Therapist works with 2 residents, different modalities

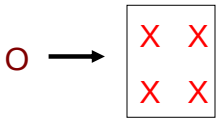


Unallocated = 30 minutes

Allocated = 30 minutes/2 = 15 minutes

Group

Therapist works with 2+ residents, same modality



Unallocated = 30 minutes with 25% cap of total therapy time performed in a group setting

O = Therapist X= Resident

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BE PROACTIVE ABOUT THE FUTURE

- Start looking at the MDS 3.0 with the team now
- Determine who will be responsible for which sections of the MDS 3.0
- Begin the interviewing techniques – Now!
- Print the MDS 3.0 User's Guide and forms and start getting familiar
- Invest in $$$ to train your staff
- Understand that the learning curve that goes with this new assessment instrument is going to impact coding accuracy and reimbursement

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MI Choice Update

Long-Term Care Supports and Services
Advisory Commission

May 24, 2010

Michael Daeschlein
Michigan Department of Community Health

2010 Priorities

- Clinical Quality Assurance Reviews
- Administrative Reviews
- Quality Management Plan
- Nursing Facility Transitions
- Data Systems Development
- Coordination with Native American Tribes
- Analysis of the Support Coordinator role

Clinical Quality Assurance Reviews

- New review team
- More precise reviews
- On-site record reviews, interviews and home visits
- Focus areas:
  - Access
  - Participant-centered service planning and delivery
  - Provide capacity
  - Participant safeguards
  - Participant rights and responsibilities
  - Participant outcomes and satisfaction
  - Systems performance
  - Administration
  - Services

Clinical Quality Assurance Reviews: Status

- 14 of 20 reviews completed
- 4 reports completed
- Remaining review scheduled for completion by September 1, 2010

Administrative Reviews

- Conducted by MDCH staff
- On-site record reviews and home visits
- Focus areas same as Clinical Reviews

Administrative Reviews: Status

- 15 of 20 completed
- 5 reports completed
- Remaining scheduled for completion by August 1, 2010
- Reports scheduled for completion by October 1, 2010

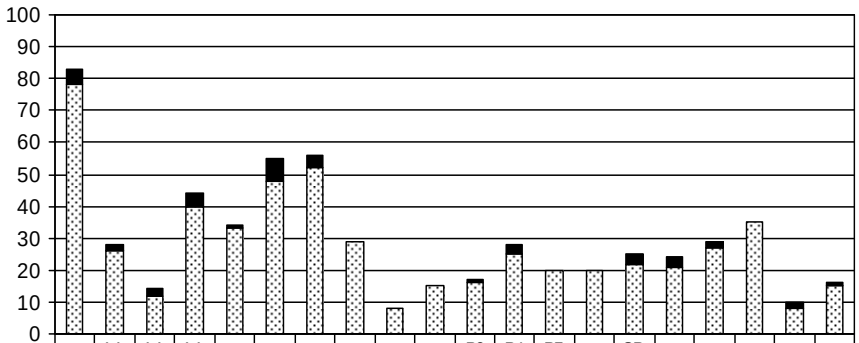
Quality Management Plan: Status

- Quality Indicators: InterRAI currently developing algorithms
- Self-determination option: 12 waiver agents achieved goal of at least 5% per waiver agent
- Nursing Facility Transitions: See below for status
- Common consumer survey: Workgroup held first meeting last week
- Local Quality Collaboratives: Under development

Waiver Agent Codes

- A&D – A & D Home Health Care, Inc., Saginaw, MI
- AAA1B – Area Agency on Aging 1B, Southfield, MI
- AAANM – Area Agency on Aging of Northwest Michigan, Traverse City, MI
- AAAWM – Area Agency on Aging of Western MI, Grand Rapids, MI
- BB – Region 3B AAA @ Burnham Brook Center, Battle Creek
- DAAA – Detroit Area Agency on Aging, Detroit, MI
- HHS R8 – Health Options, Grand Rapids, MI
- HHS R14 – Health Options, Grand Rapids, MI
- MORC – Macomb Oakland Regional Center, Clinton Township, MI
- NMCSA – Northeast MI Community Service Agency, Inc., Alpena, MI
- NHCM – Northern Lakes Community Mental Health, Traverse City, MI
- NMRHS – Northern Michigan Regional Health System, Petoskey, MI
- R2 AAA – Region 2 Area Agency on Aging, Brooklyn, MI
- R4 AAA – Region 4 Area Agency on Aging, St. Joseph, MI
- R7 AAA – Region VII Area Agency on Aging, Bay City, MI
- SRRES – Senior Resources, Muskegon Heights, MI
- SRSVCS – Senior Services of Kalamazoo, Kalamazoo, MI
- TIC – The Information Center, Taylor, MI
- TSA – The Senior Alliance (AAA), Wayne, MI
- TCOA – Tri-County Office on Aging, Lansing, MI
- UPCAP – Upper Peninsula Area Agency on Aging, Escanaba, MI
- VAAA – Valley Area Agency on Aging, Flint, MI

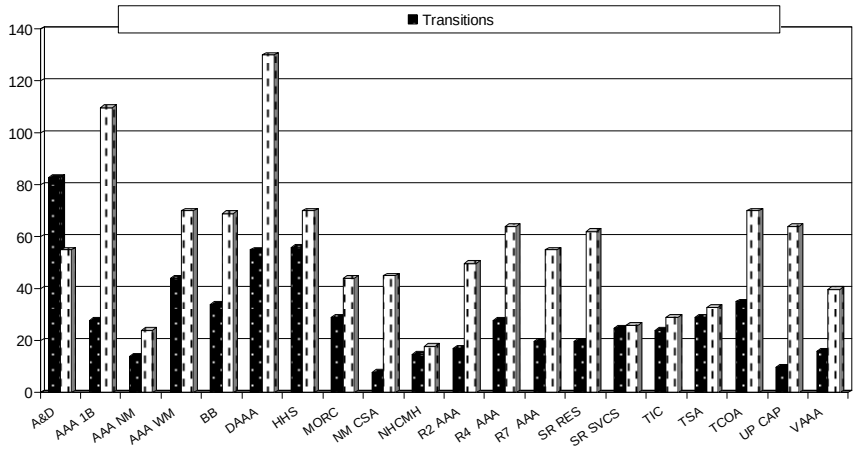
Transitions by Waiver Agent 2010 - 590



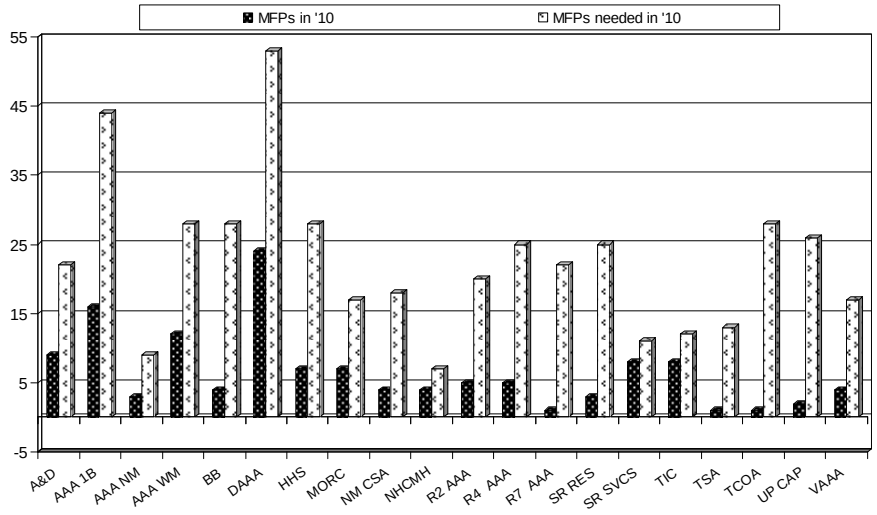
	A&D	AAA 1B	AAA NM	AAA WM	BB	DAAA	HHS	MORC	NM CSA	NHCMH	R2 AAA	R4 AAA	R7 AAA	SR RES	SR SVCS	TIC	TSA	TCOA	UP CAP	VAAA
Other Comm.	5	2	2	4	1	7	4	0	0	0	1	3	0	0	3	3	2	0	2	1
MI Choice	78	26	12	40	33	48	52	29	8	15	16	25	20	20	22	21	27	35	8	15

NFT Benchmark for FY 2010

as of 4/12/10



MFP Benchmarks for FY 2010



CIL Codes

- AACIL – Ann Arbor CIL
- BWCIL – Blue Water CIL
- CA – Capital Area CIL, Lansing
- CC – Community Connections
- DAKC – Disability Advocates of Kent County
- DCJ – disABILITY Connections, Jackson
- DC – Disability Connections, Muskegon
- DNOM – Disability Network Oakland & Macomb
- DNLS – Disability Network Lakeshore
- DNMM – Disability Network Mid-Michigan
- DNSW – Disability Network Southwest Michigan
- DNN – Disability Network Northern Michigan
- DNWC – Disability Network Wayne County
- SAIL – Superior Alliance for Independent Living
- TDN – The Disability Network, Flint

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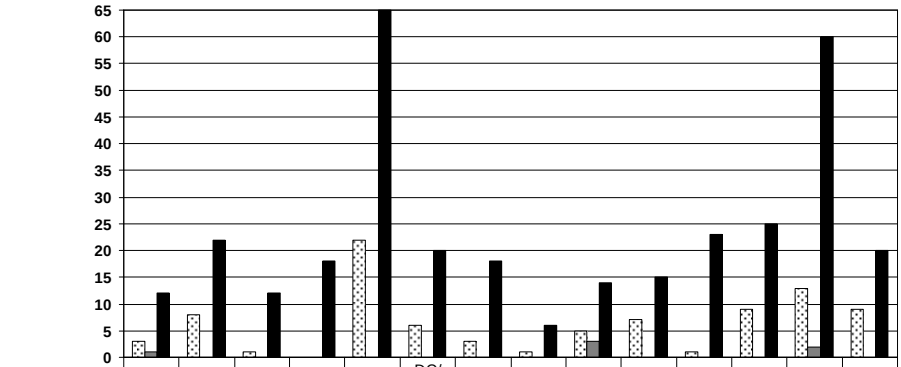
FY ’10 Transitions by CIL - 88



	AACIL	BWCIL	CACIL	DAKC	DC/J	DC/ Muskegon	DN/OM	DNLS	DN/MM	DN/SW	DN/NM	DN/WC	SAIL	TDN
Transitioned	3	8	1	0	22	6	3	1	5	7	1	9	13	9
Under contract	1								3				2	
Estimated	12	22	12	18	65	20	18	6	14	15	23	25	60	20

Data Systems Development

- Contract with the Center for Information Management
  - Nursing Facility Transition and Money Follows the Person data
  - Waiting list data
  - Critical incident reporting
  - Financial tracking
- Status: development work has started on the first two projects

MFP proposal to CMS: Status

- Approved 100% funding for two positions:
  - Quality Assurance Specialist
  - Data entry position
- Not approved: two proposals for research on direct service worker issues

Coordination with Native American Tribes: Status

- UPCAP, Region 3B AAA (SW Michigan) and AAA of Northwest Michigan continue work to improve access
- Meetings are being planned with the Little River Band of Ottawa Indians (West Michigan) and the 5 waiver agents that serve that Tribe

Analysis of the Support Coordinator Role

Plan to convene a workgroup in 4th quarter. Purpose:

- analyze the required activities and documentation
- analyze SC: participant rations and impact on job duties
- Identify opportunities for streamlining, efficiencies through technology, policy barriers
- Identify best practices
- Develop strategies and benchmarks for improvement

For additional information:

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May ___, 2010

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Michigan Department of Community Health
201 Townsend Street
Lansing, Michigan 48913

Dear Ms. Olszewski:

The Governor's Executive Order No. 2010-4 issued on March 31, 2010 establishes the Health Insurance Reform Coordinating Council to plan for the implementation of the Patient Protection and Affordable Care Act (PPACA) in Michigan, perhaps the single most significant piece of Federal health care legislation passed since Medicare and Medicaid in the mid-1960s. PPACA addresses Aging, Long Term Care, Medicare and Medicaid reform issues and has generated a great deal of interest across all of these sectors.

The Long Term Care Supports and Services Advisory Commission (LTCSS) has key interests that we have been following around the LTC areas of the act: the CLASS Act; the MA Community First Choice Option; the extension of the MA Money Follows the Person (MFP) Rebalancing Demonstration; the application of spousal impoverishment protections; additional funding for ADRCs; improved coordination and protection for the dual eligible population; New Delivery Models and Demonstrations; Enhancing Health Care Workforce Education, Training and Support, as well as Expanding Access to Health Care Coverage and applicable wellness improvements in Medicare such as closing the "donut hole" in the Part D Prescription Drug coverage, prevention coverage and chronic care management initiatives.

Last November, the LTCSS Advisory Commission asked OSA staff to provide us with a preliminary analysis of the Congressional House and Senate bills comparing the various components to the 2005 MA LTC Task Force recommendations. We have asked for continuing updates from staff to keep us informed on these key health care reform initiatives, when and how they might be implemented. We have a serious interest and commitment in supporting key LTC issues and the implementation of health care coverage.

How can we help you and the new Coordinating Council with this tremendous endeavor to secure additional federal resources for Michigan over the next decade? The LTCSS Advisory Commission stands ready and willing to help. Please let us know what we can do to be of service.

Sincerely,

RoAnne Chaney, Chairperson
Michigan Long-Term Care Supports and Services Advisory Commission

www.michigan.gov
(To Print: use your browser's print function)
Release Date: March 31, 2010
Last Update: March 31, 2010
Contact: Liz Boyd 517-335-6397

Governor Granholm Issues Executive Order Implementing Patient Protection and Affordable Health Care Act

March 31, 2010

Health insurance reform council to help reduce costs for citizens, businesses

LANSING - Governor Jennifer M. Granholm today established a Health Insurance Reform Coordinating Council within state government to identify steps that must be taken to ensure that Michigan citizens reap the full benefits outlined in the Patient Protection and Affordable Health Care Act signed into law by President Obama last week. The council will be chaired by Michigan Department of Community Health (DCH) Director Janet Olszewski.

The governor's executive order creates an Office of Health Insurance Consumer Assistance within the Office of Financial and Insurance Regulation (OFIR) and an ombudsman to help provide consumers with information regarding health care insurance, assist with the filing of complaints, and to ensure compliance with laws and regulations relating to health care insurance.

"Health care reform is designed to give Michigan families and businesses more control over their own health care, provide them with the security and stability that come with health care coverage, and reduce overall health care costs," Granholm said. "After waging a long and hard fight for this historic legislation, we want to ensure that we are doing everything we can to help citizens benefit under the new law."

As outlined in Executive Order 2010-4, the Health Insurance Reform Coordinating Council will conduct a comprehensive evaluation of the law and identify steps that the state must take to further enhance access to health care, reduce costs and improve the quality of health care in Michigan. The council also will develop a coordinated and efficient response to implementation of the act and engage relevant stakeholders in the process.

In addition to the DCH director and OFIR commissioner, the council will be comprised of the directors of the DCH Medical Services Administration; the Department of Human Services; the Department of Technology, Management and Budget; and the Office of the State Employer, plus the state budget director and state personnel director.

"We want to ensure that Michigan residents and businesses will benefit from this new federal law through enhanced access to quality and affordable health care, critical insurance market reforms, and reductions in the cost of health care for Michigan families and job providers," Granholm said. "This legislation reinforces the state of Michigan's longstanding commitment to improving the health of state residents by increasing citizen access to health care, reducing costs and improving the quality of health care."

As a first step in helping citizens gain access to information on the Patient Protection and Affordable Health Care Act and how it affects them, the state of Michigan has established a Web site at: www.michigan.gov/healthcarereform

# # #

Related Documents
> Executive Order 2010-4 - 362579 bytes PDF

www.michigan.gov
(To Print: use your browser's print function)

Release Date: March 31, 2010
Last Update: April 06, 2010

EXECUTIVE ORDER No. 2010 - 4

DEPARTMENT OF COMMUNITY HEALTH
DEPARTMENT OF ENERGY, LABOR, AND ECONOMIC GROWTH

IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the Governor;

WHEREAS, under Section 8 of Article V of the Michigan Constitution of 1963, each principal department of state government is under the supervision of the Governor unless otherwise provided by the Constitution;

WHEREAS, under Section 8 of Article V of the Michigan Constitution of 1963, the Governor is responsible to take care that the laws be faithfully executed;

WHEREAS, the Patient Protection and Affordable Care Act, Public Law 111-148, as amended, was duly enacted by the United States Congress and the President of the United States and is now the law of the land;

WHEREAS, Michigan residents and businesses will benefit from this new federal law through enhanced access to quality and affordable health care, critical insurance market reforms, and reductions in the cost of health care for Michigan families and job providers;

WHEREAS, enactment of the Patient Protection and Affordable Care Act reinforces the State of Michigan's longstanding commitment to improving the health of state residents by increasing citizen access to health care, reducing costs, and improving the quality of health care;

WHEREAS, a coordinated response by the executive branch of this state is necessary for the implementation of the Patient Protection and Affordable Care Act and to assure that this state takes appropriate further action to increase access, reduce costs, and improve the quality of health care in Michigan;

NOW THEREFORE, I, Jennifer M. Granholm, Governor of the State of Michigan, by virtue of the power vested in the Governor by the Michigan Constitution of 1963 and Michigan law, order the following:

I. DEFINITIONS

As used in this Order:

A. "Civil Service Commission" means the commission created under Section 5 of Article XI of the Michigan Constitution of 1963.

B. "Commissioner of Financial and Insurance Regulation" means the head of the Office of Financial and Insurance Regulation.

C. "Department of Community Health" or "Department" means the principal department of state government created as the Department of Mental Health under Section 400 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.500, and renamed the Department of Community Health under Executive Order 1996-1, MCL 330.3101.

D. "Department of Human Services" means the principal department of state government created as the Department of Social Services under Section 450 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.550, renamed the Family Independence Agency under 1995 PA 223, MCL 400.1, and renamed the

Department of Human Services under Executive Order 2004-38.

E. "Department of Technology, Management, and Budget" means the principal department of state government created as the Department of Management and Budget under Section 121 of The Management and Budget Act, 1984 PA 431, MCL 18.1121, and renamed under Executive Order 2009-55, MCL 18.441.

F. "Health Insurance Reform Coordinating Council" or "Council" means the council created within the Department of Community Health under Section II of this Order.

G. "Office of Financial and Insurance Regulation" means the office within the Department of Energy, Labor, and Economic Growth established by Executive Order 2000-4, MCL 445.2003, as the Office of Financial and Insurance Services and renamed the Office of Financial and Insurance Regulation under Executive Order 2008-2, MCL 445.2005.

H. "Office of the State Employer" means the autonomous office created within the Department of Management and Budget under Executive Order 1979-5, whose duties include, but are not limited to, those assigned by Executive Orders 1979-5, 1981-3, 1988-6, 2002-18, 2004-31, 2007-30, 2008-22, and 2009-55.

I. "Patient Protection and Affordable Care Act" or "Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010.

J. "State Budget Director" means the individual appointed by the Governor under Section 321 of The Management and Budget Act, 1984 PA 431, MCL 18.1321.

K. "State Personnel Director" means the administrative and principal executive officer of the Civil Service Commission provided for under Section 5 of Article XI of the Michigan Constitution of 1963 and Section 204 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.304.

II. HEALTH INSURANCE REFORM COORDINATING COUNCIL

A. The Health Insurance Reform Coordinating Council is created as an advisory body within the Department of Community Health.

B. The Council shall consist of the following members:

1. The Director of the Department of Community Health.

2. The Director of the Department of Human Services, or his or her designee from within the Department of Human Services.

3. The Director of the Department of Technology, Management, and Budget, or his or her designee from within the Department of Technology, Management, and Budget.

4. The State Budget Director, or his or her designee from within the State Budget Office.

5. The State Personnel Director, or his or her designee from within the Civil Service Commission.

6. The Director of the Office of the State Employer, or his or her designee from within the Office of the State Employer.

7. The Commissioner of Financial and Insurance Regulation, or his or her designee from within the Office of Financial and Insurance Regulation.

8. The Director of the Medical Services Administration within the Department of Community Health.

C. The Director of the Department, or his or her designee, shall serve as the Chairperson of the Council. The Council shall elect a member of the Council to serve as Vice-Chairperson of the Council.

III. CHARGE TO THE COUNCIL

A. The Council shall act in an advisory capacity to the Governor and the Director of the Department of Community Health and shall do all of the following:

1. Conduct a comprehensive evaluation of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended, and the potential impact of the Act upon the health care system within this state to identify crucial decision points or state action items necessary to comply with the Act or to further enhance access to health care, reduce costs, and improve the quality of health care.

2. Identify and recommend mechanisms to assure a coordinated and efficient state response to implementation of the Act.

3. Engage with relevant stakeholders to assist in the development of recommendations for implementation of the Act.

4. Facilitate collaboration with appropriate federal agencies when necessary regarding the establishment of new rules, regulations, or mechanisms for implementation of the Act.

5. Develop recommendations for implementation of a health insurance exchange in this state.

6. Analyze the impact of the Act on state departments and agencies, including, but not limited to, budgetary implications of the Act for this state.

7. Identify federal grants, pilot programs, and other non-state funding sources to assist with implementation of the Act and other measures to further enhance access to health care, reduce costs, and to improve the quality of health care in this state.

8. Recommend executive action or legislation to effectively and efficiently implement the Act.

9. Submit to the Director of the Department and to the Governor a strategic plan for the effective and efficient implementation of the Act.

10. Perform other functions related to implementation of the Act as requested by the Director of the Department or the Governor.

B. The Council may establish advisory workgroups composed of Council members or others deemed necessary by the Council to assist the Council in performing its duties and responsibilities. Members may include, without limitation, doctors, nurses, health care professionals, patient advocates, representatives from health plans and health insurers, and others with expertise in the private sector, organized labor, government agencies, and at institutions of higher education. The Council may adopt, reject, or modify any recommendations proposed by an advisory workgroup.

IV. OPERATIONS OF THE COUNCIL

A. The Council shall be staffed and assisted by personnel from the Department, subject to available funding. Any budgeting, procurement, or related management functions of the Council shall be performed under the direction and supervision of the Director of the Department.

B. The Council shall adopt procedures consistent with Michigan law and this Order governing its organization and operations.

C. A majority of the members of the Council serving constitutes a quorum for the transaction of the Council's

business. The Council shall act by a majority vote of its serving members.

D. The Council shall meet at the call of the Chairperson and as may be provided in procedures adopted by the Council.

E. The Council may, as appropriate, make inquiries, studies, investigations, hold hearings, and receive comments from the public. The Council may also consult with outside experts in order to perform its duties, including, but not limited to, experts in the private sector, organized labor, government agencies, and at institutions of higher education.

F. Members of the Council shall serve without compensation. Members of the Council may receive reimbursement for necessary travel and expenses consistent with relevant statutes and the rules and procedures of the Civil Service Commission and the Department of Technology, Management, and Budget, subject to available funding.

G. The Council may hire or retain contractors, sub-contractors, advisors, consultants, and agents, and may make and enter into contracts necessary or incidental to the exercise of the powers of the Council and the performance of its duties as the Director of the Department deems advisable and necessary, in accordance with this Order, the relevant statutes, and the rules and procedures of the Civil Service Commission and the Department of Technology, Management, and Budget, subject to available funding.

H. The Council may accept donations of labor, services, or other things of value from any public or private agency or person.

I. Members of the Council shall refer all legal, legislative, and media contacts to the Department.

V. OFFICE OF FINANCIAL AND INSURANCE REGULATION

A. The Commissioner of Financial and Insurance Regulation shall establish within the Office of Financial and Insurance Regulation an Office of Health Insurance Consumer Assistance to do all of the following:

1. Coordinate with the Office of Financial and Insurance Regulation and with consumer assistance organizations the receipt and response to inquiries and complaints concerning health insurance coverage relating to federal health insurance requirements and related requirements under Michigan law.

2. Assist with the filing of complaints and appeals, including filing appeals with an internal appeal or grievance process of a group health plan or health insurance issuer and with the provision of information about any external appeal process.

3. Collect, track, and quantify problems and inquiries encountered by consumers.

4. Educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage.

5. Assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance.

6. Resolve problems with obtaining premium tax credits under Section 36B of the federal Internal Revenue Code of 1986.

7. Collect and report relevant data to the United States Secretary of Health and Human Services to the extent provided by federal law on the types of problems and inquiries encountered by consumers.

B. The Commissioner of Financial and Insurance Regulation shall designate an individual within the Office of Financial and Insurance Regulation to serve as the Michigan Health Insurance Consumer Assistance Ombudsman and to supervise and direct the Office of Health Insurance Consumer Assistance.

VI. MISCELLANEOUS

A. The Director of the Department of Community Health shall provide direction and supervision for the implementation of Sections II, III, and IV of this Order. The Commissioner of Financial and Insurance Regulation shall provide direction and supervision for implementation of Section V of this Order.

B. All departments, committees, commissioners, or officers of this state, or of any political subdivision of this state, shall give to the Health Insurance Reform Coordinating Council or to any member or representative of the Council, any necessary assistance required by the Council or any member or representative of the Council, in the performance of the duties of the Council so far as is compatible with its, his, or her duties. Free access shall also be given to any books, records, or documents in its, his, or her custody, relating to matters within the scope of inquiry, study, or review of the Council.

This Order is effective upon filing.

Given under my hand this 31st day of March, in the year of our Lord, two thousand and ten.

_____
JENNIFER M. GRANHOLM
GOVERNOR

BY THE GOVERNOR:

_____
Secretary of State

State Profile Tool Grant
Update to LTC Supports and Services Advisory Council
May 24, 2010

The purpose of the State Profile Tool grant is to develop a profile of Michigan's publicly-funded LTC system and assist the Centers for Medicare and Medicaid Services (CMS) in the development of national benchmarks to assess states' progress toward achieving a balanced, person centered long term supports (LTS) system. A balanced system offers individuals with a reasonable array of options that include adequate choices of both community and institutional options. For purposes of this project, LTS is defined as state funded (primarily Medicaid) supports.

The Profile of Michigan's Publicly-Funded LTC Services developed under Phase I of the project is available on-line at: http://www.michigan.gov/ltc/0,1607,7-148--225858--,00.html.

Phase II data collection activities have concluded and participating states are awaiting an analysis of findings from Ascellon, the national balancing indicator contractor. A draft report is expected to be released in July.

Work continues with the Stakeholder Advisory Group on development of state-specific indicators. Indicators are being considered for the domains of dementia, choice and control, quality, and utilization.

PHI has concluded the data mining and interview process, and has presented OSA with a draft Overview of Findings from the Workforce Measures Database Project Work. PHI found that the availability, quality and consistency of workforce data vary across the long support sectors (home and community-based services, assisted living, adult foster care, homes for the aged, nursing facilities) and makes specific recommendations for establishing a system to collect this information on an ongoing basis. A formal presentation of the report will be made to the LTCSS Advisory Commission at a future date.

As previously reported, SPT funding will be used to conduct a survey of direct care workers employed by self-directing consumers in the MI Choice program to help DCH understand the motivations, needs, competencies, and background of direct services workers who provide care to individuals receiving services through the self-determination option of the MI Choice waiver program. The data will be used to develop strategies to retain existing workers and recruit new ones as the demand for self-direction grows.

CMS is working with other partners (ASPE, AARP, and federal Office of Civil Rights) that want to do additional work with the ten SPT states. In exchange, CMS is offering supplemental awards (average $200,000 for a 2-year period of work) for this purpose. Tasks for the supplemental award period include testing refined measures and the feasibility of collecting the information on a nation-wide basis (ASPE), field-testing a scorecard on states' progress in rebalancing (AARP), and using the indicators to measure compliance with Olmstead (Office of Civil Rights). The majority of this work is expected to begin in early Spring 2011. Michigan intends to apply for supplemental funding. Additional information will be provided in a future report.

The next meeting of the Stakeholder Advisory Committee is June 18, 2010.

For additional information contact Jane Church at 517-241-9173 or **churchja@michigan.gov**.

Michigan Long-Term Care Supports & Services Advisory Commission
Finance Reform Workgroup

Task Force Recommendation #9: Adapt Financing Structures that Maximize Resources, Promote Consumer Incentives, and Decrease Fraud.

Responsible	Strategies / Action Steps	Status
Legislature - out of scope for workgroup	1. Michigan should decouple its estate tax from the federal estate tax to make more revenue available.	
Staff	2. Michigan should identify sources of non-federal tax revenue that are utilized to provide LTC and support services for Medicaid consumers, and create policies and procedures that will allow these funds to be used as local match to capture additional federal Medicaid dollars for long-term care and supports.	Could or has had focus but little progress
Health Care Reform	3. The Michigan Congressional Delegation should: a. Advocate for the removal of the congressional barrier imposed on the development of Partnership program by states between Medicaid and long-term care insurance.	Results have occurred but more could happen
Health Care Reform	b. Strongly advocate that the federal government assume full responsibility for the health care needs of individuals who are dually eligible for Medicare and Medicaid.	Results have occurred but more could happen
Health Care Reform	c. Urge the Congress to revise the current Federal Medical Assistance Percentage (FMAP) formula to a more just methodology using Total Taxable Resources or a similarly broader measure and to shorten the time frame from the data reporting period to the year of application.	Letter sent reflecting formal position statement from the Commission
Legislative	4. Subject to appropriate reviews for actuarial soundness, overall state budget neutrality, and federal approvals, Michigan should establish a mandatory estate preservation program instead of establishing a traditional Medicaid Estate Recovery Program.	Formal position statement adopted by Commission
Workgroup	5. Legislation that promotes the purchase and retention of long-term care insurance policies and that addresses ratemaking requirements, insurance standards, consumer protections, and incentives for individuals and employers should be drafted, reviewed, introduced, and enacted after review by a representative group of consumers, advocates, and providers.	Guiding principles adopted by Commission

Responsible		Strategies / Action Steps	Status
Health Care Reform	6.	Three specific strategies aimed at increasing the number of people in Michigan who have long-term care insurance should be implemented: a) gain federal approval for the use of Long-Term Care Insurance Partnership Programs; b) expand the state employees' self-funded, long-term care insurance program; and c) examine the possibility of a state income tax credit for purchase and retention of long-term care insurance.	Incorporated in CLASS Act portion of PPACT
Health Care Reform	7.	Tax credits and tax deductions for the purchase of long-term care insurance policies and for "out of pocket costs" for LTC should be considered.	Incorporated in CLASS Act portion of PPACT
Workgroup and Legislature	8.	A "special tax exemption" for taxpayers who provide primary care for an eligible parent or grandparent (and possibly others) should be explored. Based upon a $1,800 exemption proposed in legislation introduced in 2005, the Senate Fiscal Agency estimates cost to the state in reduced revenue at less than $1 million.	Michigan legislation introduced with no real movement
Workgroup and State Staff		As an initial step, Michigan should adopt a Case Mix reimbursement system to fund LTC services and support. This approach sets provider rates according to the acuity mix of the consumers served. The higher the acuity, the higher the rate paid to the provider due to the resources needed to care for the consumers. As the long-term care system evolves, other appropriate funding mechanisms should also be considered and adopted.	Integrated Payment Model incorporates the principles and addresses the issue
Workgroup	9.	Michigan should encourage and strengthen local and regional programs that support caregivers in their care giving efforts.	Uncertain ability to impact due to change in the environment
Staff – out of scope for workgroup	10.	An ongoing and centralized data collection process by DHS of trusts and annuities information should continue to be used to guide the need for state regulation.	
Staff – out of scope for workgroup	11.	There should be ongoing review and strengthening, along with strict and consistent enforcement, of laws and regulations governing the inappropriate use of trusts and annuities for Medicaid eligibility.	

Responsible	Strategies / Action Steps	Status
Staff	12. There must be more frequent, vigorous, and publicized prosecution of those who financially exploit vulnerable adults.	
Staff – out of scope for workgroup	13. State agencies should cooperate in discovering and combating Medicaid fraud, and recovering funds paid for inadequate care.	
Workgroup	14. New legislation for the regulation by the state of "trust mills" and annuity companies should be enacted. This legislation should address the prevention of abusive sales tactics through the implementation of insurance industry regulations, registration of out-of-state companies, and prescreening of sales materials.	Could or has had focus but little progress
Staff – out of scope for workgroup	15. Appropriate state agencies should analyze and quantify the relationship between public and private resources, including both time and money, spent on LTC. This analysis should be used as a way to obtain a match for federal Medicaid dollars.	Integrated Payment Model addresses many of these issues
Staff – out of scope for workgroup	16. The state should study and pursue aggressive Medicare recovery efforts.	
Workgroup	17. Medicaid eligibility policies should be amended to: a. Permit use of patient pay amounts for past medical bills, including past nursing facility bills. b. Require full certification of all Medicaid nursing facilities. c. Require dual certification of all nursing facilities.	In Policy Could or has had focus but little progress Could or has had focus but little progress
Uncertain ability to impact due to change in the environment	18. Full funding for an external advocacy agency on behalf of consumers accessing the array of supports and services overseen by the SPE system. Based on a conservative figure, the total budget line for this item would be $4.3 million. Of the increase, $2million would be to bring the State Long-Term Care Ombudsman program into compliance with national recommendations; $2.3 million would go to the external advocacy organization outlined in Section 8 of the Model Act.	Incorporated in PPACT through ADRC initiatives

Consumer Inclusion/Value of Consumers

Definition (who)

In a long term care system that is based on consumer choice and control, consumers and their *representatives* have a meaningful role in the development and oversight of the system.

The input of consumers is essential to ensuring the effectiveness and responsiveness of long term care programs.

Consumer is defined as “an adult who uses long term care supports and services, or a family member/friend involved in providing long term care supports and services on a regular basis.”

Essential Elements (what)

- All aspects of long term care policy will include consumers in the development, implementation and delivery.

- Programs are built around consumers’ needs and preferences as they define them. Consumers see their needs directly and can identify what they require and prefer.

- In every long term care program and in every long term care grant, there is a line item devoted to consumer support.

- Consumer participation is valuable; therefore, a stipend is provided to compensate consumers for their time.

- The diversity of consumers necessitates a diversity of options to support their participation.

    - Barriers to participation (accessibility, accommodations, transportation, interpretive services, dependant care, etc,) are addressed.
    - Materials are provided in alternative formats with explanation of unfamiliar, specialized terminology and acronyms.

- Opportunities are provided outside of meeting agendas for consumers to meet with each other informally to build knowledge, rapport and confidence.

- Consumers are adequately oriented to the policy topic to ensure a common framework among all participants.

- Specific opportunities for consumer input are incorporated into agenda and program schedules.

- There is continuous effort to find and empower a diverse group of consumers interested in providing meaningful input. Diverse includes but is not limited to: race, ethnicity, disability, age, culture, gender, gender expression, sexual orientation, geographic location, socio-economic status.

- Feedback is routinely provided to ensure consumer participants are kept informed of the impact/results of their participation/input.

Values and Principles (why)

Consumer involvement is a logical, common sense approach to ensuring the effectiveness of long term care policies and programs.

Consumers have valuable knowledge and unique experience that only they can share and that providers and professionals need to know.

No one knows and appreciates the effectiveness of the long term care system better than consumers of that system.

Well-publicized consumer participation boosts confidence in government efforts by letting the public at large see that government values citizens' ideas.

Consumers who are able to voice their suggestions and concerns have a more positive view of their health care, have improved outcomes and quality of life, and reduced hospitalizations and secondary conditions.